

PANHANDLE HEALTH DISTRICT CUSTOMER SERVICE COMPLAINT FORM

DATE RECEIVED:	DIVISION/SERVICE:
RECEIVED BY:	SUPERVISOR REFERRED TO:

METHOD		
1)	PHONE	()
2)	IN PERSON	()
3)	BY LETTER	()
4)	OTHER	()

COMPLAINANT: NAME: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

SEPTIC PERMIT No. or FOOD ESTABLISHMENT: _____
(if Env. Health Related)

OTHER: _____

CIRCUMSTANCES SURROUNDING COMPLAINT:
(To be completed by appropriate supervisor only)

Name of Staff Involved: _____

Date of Initial Contact: _____

Date of Last Contact: _____

COMPLAINT:

INVESTIGATION:

COMMENTS / FINDINGS (Include staff input):**MANAGEMENT DECISION:****Division Director Signature:****Date:****District Director Signature:****Date:**

Date Completed:

Time Spent:

Customer Service Complaint Procedure (Policy 1-3)

Purpose: *This is primarily intended to address complaints received from our clients that relate to staff or program delivery issues.*

1. The staff person who is first contacted can complete the top portion (complainant section) of the complaint form.
2. Supervisor contacts the complainant and thoroughly completes the complaint form.
3. Supervisor investigates the complaint, documents the efforts taken to research the issue, and describes how the issue was resolved.
4. The completed form is submitted to the division director for action if necessary.
5. The completed form will then be forwarded to the District Director.